MDR Tracking Number: M5-04-3372-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on June 4, 2004.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the Cervical and Thoracic MRI studies were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Division has determined that fees were the only fees involved in the medical dispute to be resolved. As the treatment listed above were not found to be medically necessary, reimbursement for date of service 03-17-04 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 8th day of September 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division
PR/pr

MEDICAL REVIEW OF TEXAS

[IRO #5259]
3402 Vanshire Drive Austin, Texas 78738
Phone: 512-402-1400 FAX: 512-402-1012

NOTICE OF INDEPENDENT REVIEW DETERMINATION

REVISED 9/2/04

TWCC Case Number:
MDR Tracking Number: M5-04-3372-01
Name of Patient:
Name of URA/Payer:
Name of Provider: (ER, Hospital, or Other Facility)
Name of Physician: (Treating or Requesting)

August 17, 2004

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

CLINICAL HISTORY

Available information suggests that this patient reports experiencing neck and back injury while at work on ___. The patient apparently presented initially to Parkland Hospital ER where x-rays were apparently taken and found negative. The patient then presented to a Med Alert Clinic and was apparently given therapy and medications for pain. The patient presented later to a chiropractor, Dr. S, and was treated for cervical, thoracic and lumbar sprain/strain and an unspecified disc disorder. Doctor's notes do not indicate if previous x-rays were reviewed or if new studies were obtained. The patient has apparently continued to complain of neck and back pain following one month of conservative therapy. However, doctor's notes do not appear suggest discogenic signs such as radiculitis or radiculopathy. A cervical, thoracic and lumbar MRI series was obtained on 03/17/04, and cervical and thoracic images were found essentially unremarkable. Lumbar MRI report suggests 2mm central disc bulge at L5/S1with no

evidence of stenosis of facet arthropathy. Radiologist, Dr. G, suggests that these findings be correlated clinically and with plain films to determine specific symptomatic origin.

REQUESTED SERVICE(S)
Determine medical necessity for Cervical and Thoracic MRI studies for date in dispute 3/17/04.

DECISION
Denied.

RATIONALE/BASIS FOR DECISION
Cervical and thoracic MRI studies obtained 03/17/04 appear to be unsupported by available documentation, as treating doctor, Dr. S, does not appear to have reviewed previous plain films and no clinical correlation appears to be made in treatment notes prior to ordering these studies.

1. Guidelines for Chiropractic Quality Assurance and Practice Parameters, Mercy Center Consensus Conference, Aspen Publishers, 1993.

2. Clinical Practice Guideline, AHCPR Publication No. 95-0643, December 1994.

The observations and impressions noted regarding this case are strictly the opinions of this evaluator. This evaluation has been conducted only on the basis of the medical/chiropractic documentation provided. It is assumed that this data is true, correct, and is the most recent documentation available to the IRO at the time of request. If more information becomes available at a later date, an additional service/report or reconsideration may be requested. Such information may or may not change the opinions rendered in this review. This review and its findings are based solely on submitted materials.

No clinical assessment or physical examination has been made by this office or this physician advisor concerning the above-mentioned individual. These opinions rendered do not constitute per se a recommendation for specific claims or administrative functions to be made or enforced.